

**Birmingham & Solihull CCG ABI Rehabilitation Referral Form**

**Patient Details**

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| **Forename** |  | **Gender****First Language** |  |
| **Surname** |  | **D.O. B** |  |
| **Permanent Address & Telephone Number**  |  | **Current Location** ***(if not permanent address)*** |  |
| **NHS number**  |  | **GP & Practice Address** |  |
| **Does the patient have capacity?****Is the patient/or their representative aware of this referral?**  |  | **Has the patient or their representative been made aware of the sharing of information?** |  |

**NOK/Representative Details**

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| --- | --- | --- | --- |
| **Name** |  | **Address** |  |
| **Contact Number**  |  | **Email**  |  |



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| **Patient Clinical Summary including treatment so far and benefit of further ongoing rehabilitation.** **Clinical History:****Procedures, imaging, results:****Neurological (e.g. GCS, visual/hearing impairment, increased/decreased tone):** **Cognitive and psychosocial: e.g. DoLs, 1:1, PTA****Mobility (e.g. transfer / walking aids, number of staff needed, postural issues):****Continence:****Communication (e.g. Dysphasia, Dyspraxia, Dysarthria, Interpreter required):****Nutrition and hydration (e.g. NGT/PEG, restrictions, supplements, dietary requirements, assistance needed):****Skin / Tissue viability (Pressure damage, surgical wounds, location and management):** **Respiratory: (e.g. self-ventilating, oxygen requirements):****Discharge Planning (any issues to consider):****Rehabilitation Goals (Ensure they are SMART). What is realistic and achievable within 12 weeks?** *
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**Referral Details**

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| **Date of referral** |  | **Name & Position of Clinician Referring**  |  |
| **Reason for Referral - why is inpatient rehabilitation necessary?** |  |
| **If any providers have been identified/contacted, please state below who has been contacted, when and the outcome.**  |
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Please send completed form to nhsbsolccg.abireferrals@nhs.net